STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DINC	00	COMPL	ETED
		155614	B. WING			08/05/2	011
		<u> </u>	D. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	R			UNTRY CLUB DRIVE		
LINCOLN	I HILLS OF NEW A	LBANY			_BANY, IN47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	CORRECTION (X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0000							
		D	F0.6		Droporation and everytion a	f this	
		or a Recertification and	F00)00	Preparation and execution o response and plan of correct		
	State Licensure S	Survey.			does not constitute an admis		
					or agreement by the provide		
	Survey dates: A	August 1, 2, 3, 4, 5, 2011			the truth of the facts alleged	or	
					conclusions set forth in the		
	Facility number	: 000321			statement of deficiencies. T		
	Provider number	r: 155614			plan of correction is prepare and/or executed solely beca		
	AIM number: 1	100286130			is required by the provisions		
	Survey team: Gloria J. Reisert, MSW/TC				federal and state law. For		
					purpose of any allegation that	at the	
					facility is not in substantial		
	Dorothy Navetta				compliance with federal	41	
	Donna Groan Ri				requirements of participation response and plan of correct		
	Donna Groan Ki	N			constitutes Lincoln Hills Hea		
	G 1 1.				Center's allegation of compli		
	Census bed type				in accordance with Section 7		
	SNF: 8				in the State Operations Man	ual.	
	SNF/NF: 119						
	Total: 127						
	Census payor typ	pe:					
	Medicare: 22						
	Medicaid: 86						
	Other: 19						
	Total: 127						
	·						
	Sample: 24						
	Supplemental sa	mnle· 1					
	Suppremental sa	impre. 1					
	These deficienci	es also reflect state					
	_	accordance with 410 IAC					
	16.2.						
			1				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

70FX11

Facility ID:

000321

TITLE

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155614	B. WING	;		08/05/2	011
NAME OF D	DOMINED OD SLIDDI IED		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			326 CO	UNTRY CLUB DRIVE		
LINCOLN	I HILLS OF NEW AL	BANY		NEW AL	LBANY, IN47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	 	ID	DROWINED'S BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	I	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	Quality review 8/10/	/11 by Suzanne Williams, RN					
F0157	A facility must imm	nediately inform the					
SS=E	resident; consult w	vith the resident's physician;					
	and if known, notify the resident's legal						
		an interested family member					
		ccident involving the					
		ults in injury and has the					
		ing physician intervention; a					
		in the resident's physical, social status (i.e., a					
	deterioration in he						
		is in either life threatening					
		al complications); a need to					
	alter treatment sign	nificantly (i.e., a need to					
		sting form of treatment due					
	•	uences, or to commence a					
		nent); or a decision to					
		ge the resident from the					
	facility as specified	ı in 9483. i2(a).					
	The facility must a	Iso promptly notify the					
		own, the resident's legal					
		nterested family member					
	when there is a ch	ange in room or roommate					
		ecified in §483.15(e)(2); or					
		nt rights under Federal or					
	_	ations as specified in					
	paragraph (b)(1) o	of this section.					
	The facility must re	ecord and periodically					
	•	s and phone number of the					
		presentative or interested					
	family member.						
	-	ord review and interview,	F01	157	The facility will continue to		08/29/2011
		to notify the physician			immediately inform the		
		less than 60 as ordered.			resident/responsible party ar	ıd	
	_	actice affected 2 of 10			consult with the resident's		
					physician when there is a		
		ed with blood sugar			significant change in the resident's physical status tha	t	
	_	ample of 24. (Resident #			may require an alteration in		
	124, #84)				treatment.For Resident #124	, the	
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID: 7	0FX11	Facility 1			l ge 2 of 24

70FX11

Page 2 of 24

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614	(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 08/05/2	LETED
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP CODE 326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	B RIATE	(X5) COMPLETION DATE
	the facility failed of a specimen no ordered for 1 of Clostridium diff (Resident #132) C. Based on receive the facility failed and responsible check the folate comparison was This deficient presidents review sample of 24. (I Findings included A. 1. The clinic #124 was review The resident's diwere not limited II. The Nurse's not limited to "3 given 2 pudding notified. 9 P Re 47, Res given cubar & peanut bu Recheck of BS 5 bar & peanut bu	al record for Resident yed on 8/2/11 at 3:25 p.m. agnoses included, but to diabetes mellitus type Notes included, but were /20/11 8 P BS 56, Res & juice. fam & MD check of BS (blood sugar) p of medpass chocolate tter crackers. 10 P 63, Res given chocolate			MD and resident/responsible party been notified of the blood sericults of 3/20/11. For Resident/responsible party been notified of the blood sericults of 7/3/11 and 7/4/11 new orders noted. Resident was discharged from the factor on 5/14/11. For Resident #1 folate has been drawn and MD and resident/responsible party were notified of the late and results. All residents whorders for accuchecks; ordementia work-ups and ordered labs related to stools for Chave the potential to be affected. All licensed staff been inserviced on P & P in to physician notification of abnormal blood sugar results following physician orders collection of specimens for for c-diff and dementia wor and notification to physician resident/responsible party. Nursing Managers where weekly audits time works; monthly audits time months and then quarterly of all accuchecks to ensure the physician/resident/responsible party have been notified of abnormal results per facility policy. Nursing Managers where weeks; monthly times 6 week	sugar sident have sugar . No : #132, acility 70, the the ab draw th ers for ders for difficile have elated lts; for labs k-ups in and ll les 6 audits e that onsible any y weekly les 2 of rders	

000321

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155614	B. WIN			08/05/2	011
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2		1	UNTRY CLUB DRIVE		
LINCOLN	N HILLS OF NEW A	LBANY		1	LBANY, IN47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	to: "Call MD if	BS < 60 or > 450."			the lab tests are completed		
	Documentation v	was lacking the physician			according to physician orders notification is made to	s and	
	was notified afte	r the blood sugar was			physician/resident/responsib	le l	
	rechecked at 9 at	nd 10 P.M. which			party.SS Director will review		
	remained below	60.			medical record weekly times		
					weeks; monthly times 2 mon	ths	
	The Hypoglycemic	Reaction (low blood sugar)			and then quarterly of those residents with orders for a		
	policy and procedur	re provided on 8/3/11 by the			dementia work-up to ensure	that	
		was not limited to "Nursing			lab tests are performed acco		
		act physician if blood sugar is			to physician orders and that		
		re are specific call parameters.			appropriate notification is		
	level is stabilized'	necessary until blood sugar			completed.Results of above		
	level is stabilized				audits will be reported to the DON. DON will ensure addit	ianal	
	A.2. Review of the	e clinical record for Resident			training and/or counseling is	ionai	
		4 a.m., indicated diagnoses			provided as necessary. A		
	included, but were r	not limited to, diabetes			summary of the findings will	be	
	mellitus.				reported to the QA Committe		
	The Assessed 2011 rd				quarterly for a minimum of fo		
		nysician orders indicated the er dated 10/7/10 for accuchecks			quarters. DON and Administr to monitor.	ator	
		oring) before meals and at			to monitor.		
		physician to be notified					
		sugars fell below 60 or above					
		"Insulin Sliding Scale Order"					
		esident's blood sugar was 47					
		on 7/04/11. Documentation					
		physician being notified of the					
	low blood sugars.						
	During an interview	with the Director of Nursing					
	_	at 11:08 a.m., she indicated the					
	` ′	11 indicated she thought she					
		with the physician regarding					
		of 47 but was not sure and did					
		he indicated there was no					
		dicate the physician was					
	notified on the fow	blood sugar on 7/04/11.					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	I DING	00	COMPL	ETED
		155614	B. WIN			08/05/2	011
			P. (111)		ADDRESS, CITY, STATE, ZIP CODE	I	
NAME OF I	PROVIDER OR SUPPLIEF	R.		1	UNTRY CLUB DRIVE		
LINCOL	N HILLS OF NEW A	LBANY		1	LBANY, IN47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	B. The clinical re	ecord for Resident #132					
	was reviewed on	8/3/11 at 12:45 p.m. A					
	Physician Order	dated 5/7/11 included,					
	but was not limit	ted to "Stool C-diff (
	Clostridium diffi	•					
		nea) check x (times) 3".					
		, (v) 5 .					
	Review of the M	ledication Administration					
		1 indicated specimens					
	1	•					
	were obtained on 5/7, 5/8 at 3 a.m. and						
	5/8 at 11 a.m. The specimens were sent to the lab.						
		ated Specimen #1 was					
		_					
		11 and reported 5/8/11 at					
) as "none detected";					
	1 -	s received on 5/8/11 and					
	1 ^	at 11:52 a.m. as "none					
	detected." A lab	slip for Specimen #3 was					
	not observed in t	the clinical record.					
	On 8/2/11 of 1.2	5 n m the DON was					
		5 p.m., the DON was he results of Specimen					
		•					
		ible to locate the results in					
		d. She contacted the Lab					
	1 ^	el informed her they only					
	_	1 and #2 and discarded					
	Specimen #3.						
		was lacking the physician					
	1	cimen #3 had not been					
	resulted out.						
	C. 1. Review of	the clinical record for					
	Resident #70 on	8/2/2011 at 11:45 a.m.,					
		ident had diagnoses					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
II IA RIIII DING	
155614 B. WING	08/05/2011
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 326 COUNTRY CLUB DRIVE	
LINCOLN HILLS OF NEW ALBANY NEW ALBANY, IN47150	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION OF CONTROL OF	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD FOR SHOULD F	RIATE
The Redefition of the International Trades	DATE
which included, but were not limited to,	
personality disorder, anxiety, psychosis,	
depressive disorder, schizophrenia, mild	
mental retardation, and senile dementia.	
On 10/20/2010, a representative from the	
area mental health center completed an	
annual mental health assessment (PASRR	
- Pre-Admission Screening Resident	
Review Level II) due to the mental illness	
diagnoses. The recommendations	
included, but were not limited to,	
Diagnosis Review/Update by NF [nursing	
facility]; Dementia Work-up; Yearly RR	
[Resident Review] Required - (yearly not	
required if Dementia Dx [diagnosis]	
concrete); Needs Further Review; Other -	
Nursing home to update chart on	
appropriate diagnoses. The mental health	
agency had requested the nursing facility	
to clarify the dementia diagnosis - R/O	
[rule out] Dementia NOS [not otherwise	
specified].	
On 10/27/2010, the consultant psychiatrist	
visited and recommended a dementia	
work-up with various lab tests and brain	
scans to be obtained if not performed in	
the last year, including the lab test RBC	
Folate [Red Blood Count]. The Folate lab	
had been completed on 5/13/2010.	
On 11/3/2010, the consultant psychiatrist	
On 11/3/2010, the consultant psychiatrist visited again and requested the RBC	

000321

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614			(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION 00	(X3) DATE COMPI 08/05/2	LETED
	PROVIDER OR SUPPLIER		326	EET ADDRESS, CITY, STATE, ZIP CODE 3 COUNTRY CLUB DRIVE W ALBANY, IN47150	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE APPRO	BE	(X5) COMPLETION DATE
	Folate to be draw previous one being	n again due to the				
	having been draw also lacking of the responsible party	was lacking of this lab wn. Documentation was the physician and the whaving been notified of the ras well the lab not been				
	8/2/2011 at 3:50 after checking th unable to locate of drawn and of the having been notinot being drawn she had just notification.	few with RN #1 on p.m., she indicated that e clinical record, she was where the lab had been physician and family fied of the order and of it in 11/2010. She indicated fied the psychiatrist who for it to be drawn the				
F0282 SS=D	facility must be proin accordance with plan of care. A. Based on receive the facility failed orders were followers if already correcord. This defined a residents review of 2 residents review of 2 residents review.	ded or arranged by the ovided by qualified persons in each resident's written ord review and interview in to ensure physician awed not to repeat a lab impleted and in the dicient practice affected 1 riewed with a Dementia ple of 24. (Resident #27)	F0282	The facility will continue that the services provide arranged by the facility a provided by qualified per accordance with each re written plan of care. The who scheduled the lab to Resident #27 is no longer employed at the facility with the facility will be serviced by the facility will continue that the facility will continue the facility will continue that the facility will be set to the facility will be a second will be set to the facility will continue that the facility will continue that the facility will continue the facility will continue the facility will be set to the facility will be se	d or re sons in sident's nurse st for	08/29/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

70FX11

Facility ID:

000321

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614			LDING	NSTRUCTION 00	(X3) DATE COMPI 08/05/2	ETED	
	PROVIDER OR SUPPLIE		'	326 CO	ADDRESS, CITY, STATE, ZIP CODE BUNTRY CLUB DRIVE LBANY, IN47150	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	the facility failed comparison with to confirm or ne as recommended health screening affected 1 of 3 relevel II screening (Resident #70) Findings included A. 1. The clinical was reviewed on resident's diagnous not limited to prophysician Order physician Order physician signed included, but was "Dementia work the following test been done within report can be and the test or proceed blood count with the following test of the following tes	al record for Resident #27 a 8/4/11 at 9:47 a.m. The bese included, but were esenile dementia. A from the psychiatric d and dated 7/14/11 as not limited to: a-up as follows (if any of ests or procedures have in the past year and the d is obtained, then omit dure): CBC (complete			Resident #70, the lab for for has been completed. All lice nursing staff were inservice following physician orders regarding lab tests ordered dementia work-up.SS Direct review the medical record times six weeks; monthly timonths and then quarterly those residents with orders dementia work-up to ensur lab tests are performed act to physician orders and the appropriate notification is completed. Results of above audits will be reported to the DON. DON will ensure additaining and/or counseling in provided as necessary. A summary of the findings with reported to the QA Committ quarterly for a minimum of quarters. DON and Administration monitor.	ensed d on for a ctor will veekly mes 2 of for a e that cording t e e ditional s	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155614	B. WIN			08/05/2	011
			_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	ę.		326 CO	OUNTRY CLUB DRIVE		
	N HILLS OF NEW A				LBANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	1	results of the CBC					
	W/DIFF.						
	On 8/4/11 at 2:25 p.m., in interview with						
	1	eviewing the labs, she					
		BC did not need to be					
	done."						
	D 1 Daview of	the clinical record for					
	B.1. Review of the clinical record for Resident #70 on 8/2/2011 at 11:45 a.m.,						
	indicated the resident had diagnoses						
	1	but were not limited to,					
	1 *	der, anxiety, psychosis,					
	1 ^	der, schizophrenia, mild					
	mental retardation	on, and senile dementia.					
	On 10/20/2010.	a representative from the					
	1	th center completed an					
		ealth assessment (PASRR					
		Screening Resident					
	1) due to the mental illness					
	1	ecommendations					
	~	ere not limited to,					
	1	w/Update by NF [nursing					
	~	tia Work-up; Yearly RR					
	1	w] Required - (yearly not					
	1 -	entia Dx [diagnosis]					
	1 -	Further Review; Other -					
	1						
	Nursing home to	-					
		noses. The mental health					
	1	ested the nursing facility					
	1 -	mentia diagnosis - R/O					
	1 * 1	ntia NOS [not otherwise					
	specified].						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMP 08/05/2	LETED
	PROVIDER OR SUPPLIER		326 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB DRIVE LBANY, IN47150	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	visited and reconwork-up with vascans to be obtain the last year, incepolate [Red Blochad been completed] On 11/3/2010, the visited again and Folate to be drawn previous one beinwas lacking of the drawn. During an interval 8/2/2011 at 3:50 after checking the	the consultant psychiatrist mmended a dementia rious lab tests and brain ned if not performed in luding the lab test RBC od Count]. The Folate lab eted on 5/13/2010. The consultant psychiatrist a requested the RBC vn again due to the ng low. Documentation his lab having been The with RN #1 on p.m., she indicated that the clinical record, she was where the lab had been				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155614		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		•	326 CO	DDRESS, CITY, STATE, ZIP CODE UNTRY CLUB DRIVE BANY, IN47150	•	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	(X5) COMPLETION
F0285 SS=D	A facility must coo the pre-admission review program ur subpart C to the m to avoid duplicative. A nursing facility m January 1, 1989, a (i) Mental illness (2)(i) of this section health authority had independent physic performed by a nursing (A) That, because mental condition of individual requires provided by a nursing (B) If the individual retarday paragraph (m)(2)(i) State mental retarday and individual requires provided by a nursing (A) That, because mental condition of individual requires provided by a nursing (B) If the individual requires provided by a nursing (B) If the individual requires provided by a nursing (B) If the individual requires provided by a nursing (B) If the individual services, whether specialized services.	rdinate assessments with screening and resident ader Medicaid in part 483, aximum extent practicable testing and effort. Thust not admit, on or after any new residents with: as defined in paragraph (m) and the control of the individual, the the level of services are for mental retardation. The services are for mental retardation and the individual requires the dation or developmental and the individual, the the level of services are of the physical and the individual, the the level of services are of the physical and the individual, the the level of services are of the physical and the individual requires such level of the individual requires services are for mental retardation.		TAG TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	mental illness defi (ii) An individual i "mentally retarded	ned at §483.102(b)(1). s considered to be " if the individual is mentally d in §483.102(b)(3) or is a					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155614 08/05/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 326 COUNTRY CLUB DRIVE LINCOLN HILLS OF NEW ALBANY NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE person with a related condition as described in 42 CFR 1009. The facility will continue to ensure F0285 08/29/2011 Based on record review and interview, the Level II PASRR for Diagnosis facility failed to ensure Level II PASRR Review/Update recommendations [Pre-Admission Screening Resident are completed. For Resident #70, Reviews] for Diagnosis Review/Update the folate lab has been completed and consultant psychiatrist has recommendations were completed for 1 of been notified of the results. 3 residents reviewed for Level II Progress note written to reflect recommendations in a sample of 24 review of the dementia work-up residents. (Resident #70) as ordered with no change in diagnosis made based on this review. Senile Dementia dx Finding includes: remains current for this resident.All residents with Level II Review of the clinical record for Resident PASRR for Diagnosis #70 on 8/2/2011 at 11:45 a.m., indicated Review/Update recommendations have the potential to be the resident had diagnoses which affected.All licensed nursing included, but were not limited to, staff were inserviced regarding personality disorder, anxiety, psychosis, following physician orders for lab depressive disorder, schizophrenia, mild tests ordered for dementia work-ups. SS Director will review mental retardation, and senile dementia. the medical record weekly times six weeks; monthly times two On 10/20/2010, a representative from the months and then quarterly for those residents with Level II area mental health center completed an recommendations to ensure all annual mental health assessment (PASRR orders were completed and - Pre-Admission Screening Resident that diagnoses were reviewed Review Level II) due to the mental illness and updated as diagnoses. The recommendations necessary. Results of above audits will be reported to the included, but were not limited to, DON. DON will ensure additional Diagnosis Review/Update by NF [nursing training and/or counseling is facility]; Dementia Work-up; Yearly RR provided as necessary. A [Resident Review] Required - (yearly not summary of the findings will be reported to the QA Committee required if Dementia Dx [diagnosis] quarterly for a minimum of four concrete); Needs Further Review; Other guarters. DON and Administrator Nursing home to update chart on to monitor.

000321

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SUI	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	ED
		155614	B. WIN			08/05/201	1
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					OUNTRY CLUB DRIVE		
LINCOL	N HILLS OF NEW AI	LBANY		NEW A	LBANY, IN47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	-	DATE
	'' '	noses. The mental health					
	1	ested the nursing facility					
	1 *	nentia diagnosis - R/O					
		tia NOS [not otherwise					
	specified].						
	l	he consultant psychiatrist					
		nmended a dementia					
	1 ^	rious lab tests and brain					
	scans to be obtained if not performed in						
	the last year, including the lab test RBC						
		od Count]. The Folate lab					
	had been comple	ted on 5/13/2010.					
	On 11/2/2010 th	e consultant psychiatrist					
	l						
	I -	requested the RBC					
		yn again due to the					
	1 ^	ng low. Documentation					
	_	is lab having been					
	drawn.						
	During an intervi	iew with the Director of					
	~	on 8/3/2011 at 1:30 p.m.,					
	" '	labs and test results					
		elves as to the diagnosis.					
	1 ^	e psychiatrist ordered the					
		put into writing a note to					
		_					
	I -	nt or confirm the dementia					
	~						
	_	did rule out the dementia					
	· -	t the psychiatrist did not					
		d that she would have to					
		trist confirm it on the					
	next visit.						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 08/05/2	ETED
	PROVIDER OR SUPPLIER		D. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE UNTRY CLUB DRIVE LBANY, IN47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0465 SS=C	sanitary, and common residents, staff and Based on observation interview, the fact fans in the laundry of 3 fans located deficient practice affect 126 of 127 utilize the laundry. Findings include On 8/1/11 between p.m., on entrance laundry was a fart. The fan had heave fan blades blowing towels. On enter driers there was a blowing toward of the fan had heave fan blades. Proce room there was a wall near the out. Employee #1 wa	ation, record review and cility failed to ensure the ry were free of dust for 3 in laundry. This had the potential to current residents who y services.	F0	465	The facility will continue to provide a safe, functional, sanitary, and comfortable environment for residents, st and the public. Fans in the lar room have been cleaned. Cleaning schedule heen updated to include wee sanitizing of the fans in the laundry room. During weekly rounds, the fans will be moni for cleanliness. Results of the rounds will be reported to the Administrator weekly. Administrator will ensure additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the Committee quarterly for a minimum of four quarters. Do and Administrator to monitor.	undry nas ekly tored ese e	08/29/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155614 08/05/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 326 COUNTRY CLUB DRIVE LINCOLN HILLS OF NEW ALBANY NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
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CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE from the washer. The fan was blowing onto the clothing. The fan had heavy dust on the grill and fan blades. In interview with Laundry Employee #1, at this time, she indicated the fans are cleaned once a week. The Administrator provided a Preventative Maintenance Cleaning Schedule on 8/2/11 at 11:10 a.m. which lacked a date of the last cleaning. 3.1-19(f)The facility must provide or obtain laboratory F0502 services to meet the needs of its residents. SS=D The facility is responsible for the quality and timeliness of the services. The facility will continue to Based on record review and interview the F0502 08/29/2011 provide or obtain laboratory facility failed to follow-up with lab for an services to meet the needs of its ordered test for c-diff was obtained for 1 residents.Resident #132, was of 1 resident reviewed with stool discharged from the facility on 5/14/11.All residents with specimens in a sample of 24. (Resident orders for labs related to stools #132) for C-difficile have the potential to be affected. All licensed staff Findings include: have been inserviced on following physician orders for collection of specimens for labs for The clinical record for Resident #132 was c-diff.Nursing Managers will reviewed on 8/3/11 at 12:45 p.m. A review the medical record weekly Physician Order dated 5/7/11 included, times six weeks; monthly for two but was not limited to "Stool C-diff (months and than quarterly of those residents receiving orders Clostridium difficile - antibiotic for stool for C-diff to ensure that associated diarrhea) check x (times) 3". the lab tests are completed

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	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPL	ETED
NAME OF PROVIDER OR SUPPLIER LINCOLN HILLS OF NEW ALBANY			326 CC	ADDRESS, CITY, STATE, ZIP CODE DUNTRY CLUB DRIVE LBANY, IN47150	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Record May 201 were obtained or 5/8 at 11 a.m. To the lab. Lab results indice received on 5/8/2 17:22 (5:22 p.m. Specimen #2 was reported 5/9/11 as detected." A lab not observed in to On 8/3/11 at 1:22 asked to locate to #3. She was una the clinical record and the personner.	dedication Administration 1 indicated specimens 1 5/7, 5/8 at 3 a.m. and the specimens were sent to ated Specimen #1 was 11 and reported 5/8/11 at 1) as "none detected"; 12 serecived on 5/8/11 and 13 th 11:52 a.m. as "none 13 slip for Specimen #3 was 14 the clinical record. 15 p.m., the DON was 16 the results of Specimen 17 the contacted the Lab 18 the contacted the Lab 19 the contacted the Lab 19 the contacted the Lab 19 the contacted the Lab 10 the contacted the Lab 11 and #2 and discarded		according to physician orders.Results of these aud be reported to the DON. Do ensure additional training a counseling is provided as necessary. A summary of the findings will be reported to the Committee quarterly for a minimum of four quarters. It and Administrator to monited to the control of the contro	ON will nd/or he the QA	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155614 08/05/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 326 COUNTRY CLUB DRIVE LINCOLN HILLS OF NEW ALBANY NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must maintain clinical records on F0514 each resident in accordance with accepted SS=D professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. F0514 The facility will continue to Based on record review, observation and 08/29/2011 maintain clinical records on each interview, the facility failed to ensure resident in accordance with records were complete and accurately accepted professional standards documented for 1 of 2 residents reviewed and practices that are complete; accurately documented; readily for hospice services and complete accessible; and systematically documentation of blood pressure organized. For Resident #27, a monitoring for 1 of 4 residents reviewed signed certification/order has with blood pressure monitoring in a been received.All residents sample of 24 residents. (Resident # 27, receiving Hospice Services and those residents with an order for 124) accuchecks have the potential to be affected. A meeting was held Findings include: with the Hosparus Representative to review provisions within the Nursing Facility Agreement and 1. On 8/2/11 at 4 p.m., the hospice RN noted responsibilities. Licensed (registered nurse) was observed charting Nursing Staff were inserviced at the East Hall nurse station. regarding documentation of abnormal blood sugar results.SS Director will audit the medical The clinical record for Resident #27 was records of those residents with reviewed on 8/4/11 at 9:47 a.m. The orders for Hospice services resident's diagnoses included, but were weekly times six weeks; monthly not limited to, failure to thrive. The times two months and then quarterly to ensure that the resident was admitted to hospice on signed certification/orders are 7/22/11. Documentation was lacking in completed timely. Nursing the clinical record of signed Managers will complete weekly

l '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL	ETED
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	PROVIDER OR SUPPLIER N HILLS OF NEW AI			326 CO	DDRESS, CITY, STATE, ZIP CODE UNTRY CLUB DRIVE LBANY, IN47150		
				<u> </u>			(27.5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
PREFIX	Certification/Ord On 8/4/11 at 2:30 provided the Nur signed and dated Agreement inclu- to: Responsibilit of all orders issue Physician or an A be provided to Fa manner. All phy communicated to Hospice in connec Care shall be in v applicable attend however, that in emergent circum be communicated orally and confirt Hospice shall ma of all practitioner connection with (Interdisciplinary hospice Services Facility will prov services provided medical record at medical record. visit, written doc entered in Patien pertinent visit inf Facility/Hospice	lers. O p.m., social worker #1 rsing Facility Agreement 11/26/08. The ded, but was not limited lies of Hospice "(j) copies ed by a Hospice Attending Physician shall racility in a timely sician orders o Facility on behalf of rection with the Plan of writing and signed by the ing practitioner, provided the case of urgent or stances such orders may d by the practitioner med in writing thereafter. Lintain adequate records or orders communicated in the Plan of Care(l) IDG or Group) providing to a Patient in the ride documentation of all d in Patient';s Facility and in Patient's Hospice At the time of the IDG umentation will be t's medical record with formation . staff collaboration as		I	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	thly then o n cility ts will N will d/or e ue QA	
	electronic docum	an notification. Hospice nentation will be					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		URVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
		155614	B. WING 08/05/2011					
NAME OF E	PROVIDER OR SUPPLIER	!	'	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
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LINCOLN HILLS OF NEW ALBANY				NEW A	LBANY, IN47150			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
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TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
	1 1	n twenty-four(24) hours						
		the facility no later than						
		visit. Facility may						
	_	ve information from the						
	_	record during routine						
	business hours."							
	On 8/5/11 at 8 a.:	m., the DON provided						
		cation signed and dated						
		ttending Physician faxed						
	1	m the hospice on August						
	4 at 2:13 p.m.	1 8						
	2. The clinical re	ecord for Resident #124						
	was reviewed on	8/2/11 at 3:25 p.m. The						
		ses included, but were						
	1	betes mellitus type II.						
		es included, but were not						
		/11 8 P BS 56, Res given						
		ce. fam & MD notified.						
		BS (blood sugar) 47, Res						
		dpass chocolate bar &						
		ckers. 10 P Recheck of						
	1 ^	chocolate bar & peanut						
	butter crackers."	i chiocolate our & peunut						
	oditor cruckers.							
	The next entry of	on the Nurse's Notes was						
	1							
	3/21/11 at 6:15 p.m. An insulin/blood sugar log indicated at HS (night no specific time) the blood sugar was 233.							
	l • ′	was lacking of another						
	recheck after 10	C						
	Techeck after 10	p.111.						
	3.1-50(a)(1)							
					!			

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155614 08/05/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 326 COUNTRY CLUB DRIVE LINCOLN HILLS OF NEW ALBANY NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 3.1-50(a)(2)The facility must train all employees in F0518 emergency procedures when they begin to SS=D work in the facility: periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. F0518 The facility will continue to train all 08/29/2011 Based on record review and interview the employees in emergency facility failed to ensure laundry employees procedures when they begin to were trained on how to turn off the gas work in the facility; periodically valve to the dryers in an emergency for 1 review the procedures with existing staff; and carry out of 4 laundry employees interviewed. unannounced staff drills using (Employee #2) those procedures. All laundry employees, including Employee Findings include: #1, have been reinserviced regarding the location of the main gas shut off.All employees have On 8/1/11 at 12:11 p.m., Laundry been inserviced again of the Employee #2 was asked "if there were a location of the main gas shut fire in the dryer, what would you do?" off.General orientation checklist for all new employees does She indicated turn off the dryer. When include location of the main shut queried if the dryers were gas, she off for all utilities, including main indicated "Yes." gas shut off. Semi-annual When queried "where do you shut off the inservice training, including main gas?" Laundry employee #1 indicated the shut off for all utilities, will continue to be completed with all main valve is out front to turn off." employees. The post-test has Laundry Employee #1 indicated "I didn't been updated to include location know that " of main gas shut off. A summary of the completion of the inservice training will be submitted to the On 8/5/11 between 10:30 a.m. and 12 QA Committee quarterly for a p.m., personnel files were reviewed. period of four quarters. DON and Laundry Employee #2 had a hire date of Administrator to monitor. 2/26/04. A skills checklist for the laundry was reviewed and lacked reference to training for the training related to turning

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
155614		A. BUILDING 00 COMPLETED 08/05/2011					
		155614	B. WIN			08/05/2	011
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
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TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
1110		in an emergency.	1	1110			Ditte
	on the gas varve	in an emergency.					
	In interview with	the Maintenance					
		1 at 11:50 a.m., he					
		the employees where the					
		ves are when they are					
		t do any inservices or					
	write it down any	-					
	write it down any	where.					
	3.1-51(b)						
	3.1-31(0)						
F9999							
	State Findings		F9	999	The facility will continue to en that employees and nonpaid		08/29/2011
					personnel are screened for		
	3.1-14 PERSON	NEL			tuberculosis by receiving a		
					two-step tuberculin skin		
		ination shall be required			test. Volunteer #1 received 1s	st	
		ee of a facility within one			step ppd on 8/5/11 and is scheduled to receive his sec	ond	
	•	o employment. The			step.CNA #1 is no longer		
		l include a tuberculin			employed at the		
		he Mantoux method (5			facility.Receptionist and Staf		
	· ·	istered by persons having			Development Coordinator hat been educated regarding time		
	documentation of	•			completion of two-step ppds	•	
	department- appr	roved course of			all employees and necessary		
	instruction in inti	radermal tuberculin skin			nonpaid personnel.Reception	nist	
	testing, reading, a	and recording unless a			will audit all employee and	-I	
	previously positi	ve reaction can be			necessary nonpaid personne records monthly for a period		
		e result shall be recorded			one year. Results of audits v		
	in millimeters of	induration with the date			be reported to the Business		
	given, date read,	and by whom			Office Manager monthly.		
	administered. Th	e tuberculin skin test			Additional training and educa will be completed monthly as		
	must be read price	or to the employee			necessary based on the resu		
			<u>L</u>				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155614		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
		155614		LDING	00	08/05/20	
		100011	B. WIN		DDDEGG CITY CTATE ZID CODE	00/00/20	,,,
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE UNTRY CLUB DRIVE		
LINCOLN	N HILLS OF NEW AI	LBANY			LBANY, IN47150		
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TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		ne facility must assure the			these audits.		
	1	e time of employment, or					
	within one (1) m	-					
		l at least annually					
	_	yees and nonpaid					
	l *	lities shall be screened					
		For health care workers					
		d a documented negative					
		est result during the					
		e (12) months, the					
		in skin testing should					
		step method. If the first					
		a second test should be					
	_	to three (3) weeks after					
	_	e frequency of repeat					
		nd on the risk of infection					
	with tuberculosis	5.					
	This State Rule v	vas not met as evidenced					
	by:						
	Based on record	review, observation and					
	interview, the fac	cility failed to ensure					
	volunteers were	screened for tuberculosis					
	at the time of ser	vice or within one month					
	prior to service a	nd failed to ensure					
	employees receiv	ved a second step test					
	within 3 weeks a	fter the first step. This					
	deficient practice	e affected 1 of 1 volunteer					
	and 1 of 10 empl	oyee files that were					
	reviewed. (Volum	teer #1, CNA #1)					
	Findings include	:					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	COM	TE SURVEY IPLETED 5/2011
NAME OF PROVIDER OR SUPPLIER LINCOLN HILLS OF NEW ALBANY			STRE 326	EET ADDRESS, CITY, STATE, ZI COUNTRY CLUB DRIVI V ALBANY, IN47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	interview with the indicated she was had received a Pituberculosis] and file. A few minute indicated she had with the [name of determine if they one. She indicated locate documents having received a year and presents received it on this Random observated 8/4, and 8/5/2011 his therapy dog with the resident 2. On 8/5/2011 areview of Certification 1 employee file 1 a second step PP review indicated 6/16/2011 and research 18/2/2011. On 8/5/2011 at 1 with Business Of indicated the second step second step PP review indicated 6/16/2011 and research 18/2/2011.	at 9:25 a.m. during an the Administrator, she is not sure if Volunteer #1 PD [a skin test for a would have to check his test later, she returned and a checked his file and also if volunteer agency] to a had administered him ted she was unable to action of the volunteer at PPD skin test in the last ted a copy of where he had is day. Itions on 8/1, 8/2, 8/3, and the volunteer and a visiting and interacting is throughout the facility. In 11:30 a.m., record ted Nurses Aide (CNA) # acked documentation that D had been done. Record CNA #1 was hired on signed her position on 2:30 p.m., in interview office Manager #1, she cond step PPD had not one sont know why it "got				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER: 155614	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP 08/05/2	LETED		
NAME OF PROVIDER OR SUPPLIER LINCOLN HILLS OF NEW ALBANY			STREET ADDRESS, CITY, STATE, ZIP CODE 326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150					
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TAG	3.1-14(t) 3.1-14(t)(1)	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY		DATE		